

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>38 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>QUEEN ANNE'S</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL QUEENSTOWN</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>DEADY</b> Last <b>ANDRUS</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>4</b> Year <b>1966</b>		5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>April 17, 1905</b>			9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WIFE</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Pawling Dutchess Co., N.Y.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Maybury Burton Deady</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Ferriss</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>218-48-5591</b>		17. INFORMANT <b>husband</b> Address <b>LEON A. ANDRUS, QUEENSTOWN, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the stomach</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>Uncertain</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>								
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>9-2, 1966</b> , to <b>9-4, 1966</b> , that (I) (we) last saw the deceased alive on <b>9-3, 1966</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert W. Trever</b>			M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>9/4/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Trever</b>			22d. ADDRESS <b>Easton, Maryland</b>								
23a. <del>DEATH</del> CREMATION, 23b. DATE THEREOF <b>Sept. 5, 1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Wilmington, Delaware</b>					
24. FUNERAL DIRECTOR <b>James H. Burton Jr., Baltimore, Md.</b>			25a. REC'D BY REGISTRAR <b>SEP 7 1966</b>			25b. REGISTRAR'S SIGNATURE <b>John C. Judge</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<div style="display: flex; justify-content: space-between;"> <span>13256</span> <span>13249</span> </div>			
<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Talbot</span> <span style="margin-left: 100px;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <span style="margin-left: 100px;">Maryland</span> <span style="margin-left: 100px;">b. COUNTY Talbot</span>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rural - St. Michaels</span>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">St. Michaels</span>	
c. LENGTH OF STAY IN lb <span style="font-size: 1.2em;">2 wks</span>		d. STREET ADDRESS <span style="font-size: 1.2em;">Water St</span>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <span style="font-size: 1.2em;">Rio Vista Nursing Home</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <span style="font-size: 1.2em;">LUCY PEARL BAYNARD</span>		<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> <span style="font-size: 1.2em;">September 29, 1966</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Sept 8, 1874</span>
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">92</span> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <span style="margin-left: 10px;">Days</span>	<b>11. IF UNDER 24 HRS.</b> Hours <span style="margin-left: 10px;">Min.</span>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Talbot County, Md.</span>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <span style="font-size: 1.2em;">USA</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Dawson Caulk</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Margaret Donaphin</span>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="margin-left: 10px;">(If yes give war or dates of service)</span> <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">220-52-7856</span>	
<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Mrs. John Lewis, Marlon, So. Carolina</span>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Cerebral Hemorrhage</span> (b) <span style="font-size: 1.2em;">Hypertensive-atherosclerotic</span> (c) <span style="font-size: 1.2em;">cerebrovas d.</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <span style="font-size: 1.2em;">331K</span>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="font-size: 1.2em;">chronic cardiac failure</span>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <span style="margin-left: 10px;">p.m.</span>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">1953</span> <span style="margin-left: 10px;">to</span> <span style="font-size: 1.2em;">9-29-66</span> <span style="margin-left: 10px;">that (I) (we) last saw the deceased alive on</span> <span style="font-size: 1.2em;">9-29-66</span> <span style="margin-left: 10px;">and that death occurred</span> <span style="font-size: 1.2em;">1:50 A</span> <span style="margin-left: 10px;">M.</span> <span style="margin-left: 10px;">from the causes and on the date stated above.</span>			
<b>22. SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>		<b>22b. DATE SIGNED</b> <span style="font-size: 1.2em;">9-30-66</span>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <span style="font-size: 1.2em;">Raym Breeser Jr</span>		<b>22d. ADDRESS</b> <span style="font-size: 1.2em;">St Michaels md</span>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>	<b>23b. DATE THEREOF</b> <span style="font-size: 1.2em;">Oct 1, 1966</span>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Olivet Cemetery</span>	<b>23d. LOCATION (City, town or county)</b> (State) <span style="font-size: 1.2em;">St. Michaels, Maryland</span>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>		<b>25a. REC'D BY REGISTRAR</b> <span style="margin-left: 10px;">25b. REGISTRAR'S SIGNATURE</span> <span style="font-size: 1.2em;">[Signature]</span>	
<b>25c. DATE</b> <span style="font-size: 1.2em;">OCT 5 1966</span>		<b>25d. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>---</b>		d. STREET ADDRESS <b>---</b>	
3. NAME OF DECEASED (Type or print) <b>ETHEL MARIE BRAUER</b>		4. DATE OF DEATH <b>September 20, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 30, 1912</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Frank J. Hart</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Goetz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>139-34-0889</b>	
17. INFORMANT <b>August Brauer, St. Michaels, Maryland</b>		Address <b>---</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>---</b> (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>---</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) (County) (State) <b>---</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>9-21-66</b> Address (Street, city, town, or county) <b>---</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 24, 1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Patterson, New Jersey</b>	
23. FUNERAL DIRECTOR <b>L. Hamilton Harrison, St. Michaels, Md</b>		24. REC'D BY REGISTRAR <b>SEP 26 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN 1b <u>4 d.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> <u>21617</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>309 S. Commerce St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HARRY Covington Butler</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1888</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Queenstown, D.A.Co., Md.</u>
13. FATHER'S NAME <u>Charles W. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Bryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>213-20-3760</u>	17. INFORMANT <u>Wife</u> Address <u>Mrs. Ruth P. Butler, Centreville Md. 21617</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-13</u> , 19 <u>66</u> to <u>9-17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-17</u> , 19 <u>66</u> , and that death occurred at <u>8:20</u> A.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9-20-66</u>
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney, M.D.</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 19, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Centreville Maryland 21617</u>
24. FUNERAL DIRECTOR <u>James H. Butler Jr., Butler Bur. Centreville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MASSACHUSETTS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rio Vista Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma C. Cooper</b>		4. DATE OF DEATH Month <b>9</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/26/1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Reg. Nurse</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Kent Co. Md.</b>	
13. FATHER'S NAME <b>Samuel F. Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Anna Rasin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>215 48 6331</b>	
17. INFORMANT <b>Julia Matthews</b>		Address <b>P.O. Box Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Cerebrovascular</b> (c) <b>vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-19</b> , 19 <b>66</b> to <b>9-28</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-27</b> , 19 <b>66</b> , and that death occurred at <b>3:57</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>R. Lane Wroth</b>		22b. DATE SIGNED <b>9-29-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Lane Wroth</b>		22d. ADDRESS <b>St. Michaels, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/1/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Willis Wells</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1966</b>	
ADDRESS <b>Chestertown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1938

1938

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They must remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13253

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN ID <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Easton Memorial Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elizabeth</u> Last <u>PINDER</u>				4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 12 1888</u>	
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Queen Anne's Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES FRANK PINDER</u>				14. MOTHER'S MAIDEN NAME <u>Molly PINDER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>412-10-0704-A</u>		17. INFORMANT <u>Miss Bertha E. Dadds</u> Address <u>Centreville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram negative bacteremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1554</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis. Arteriosclerotic ht. disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8-30-66</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-30</u> , 19 <u>66</u> to <u>9-1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-31</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>				22b. DATE SIGNED <u>9/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Centreville, Maryland</u>	
24. FUNERAL DIRECTOR <u>James H. Butler, Jr. Easton, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

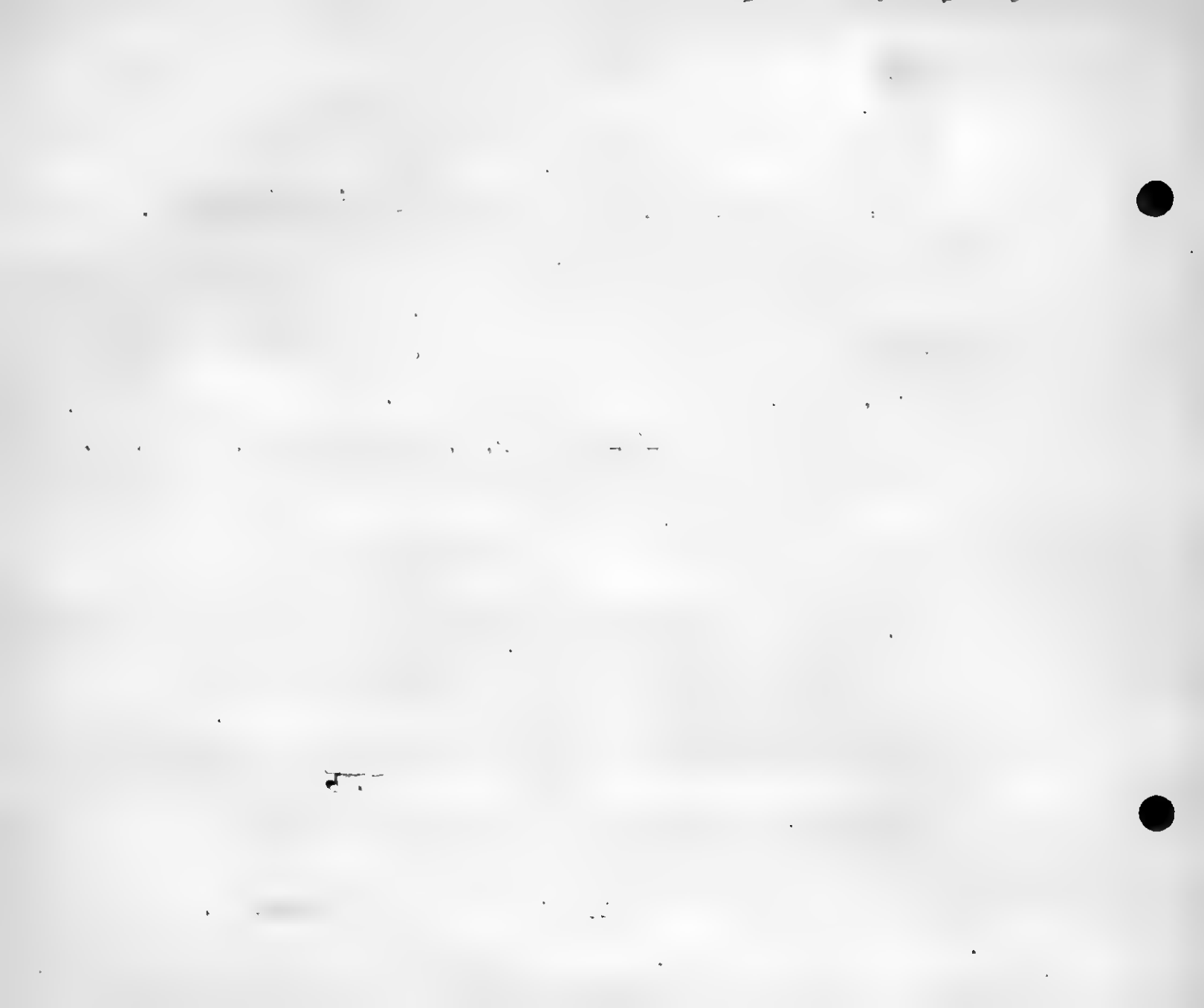


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right; font-size: 1.5em;">13254</div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Talbot</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY in 1b <b>3 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOUSE IN THE PINES, INC. EASTON</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> d. STREET ADDRESS <b>20 S. Harrison Street</b> <b>XXXXXXXXXXXXXXXXXXXX</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <b>Anna K. Earle</b> First Middle Last <b>Anna K. Earle</b>					<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>12</b> Year <b>19 66</b>				
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>7/26/1869</b>		<b>9. AGE</b> (In years last birthday) <b>97</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Talbot Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Elias O. Dawson</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna K. Groome</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>220-44-6709</b>		<b>17. INFORMANT</b> Address <b>Mrs. C. Loundes Johnson, Easton, Md.</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO <b>Chronic urinary infection</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 weeks</b> <b>2 months</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Fractured hip Sept 1966 July</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from Sept 11, 1966 to Sept 12, 1966, that (I) (we) last saw the deceased alive on Aug 31, 1966, and that death occurred at 7:15 PM from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Stephen P. Canye</b>					<b>22b. DATE SIGNED</b> <b>9-12-66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b>		
<b>22d. ADDRESS</b>					<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>9/14/1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Spring Hill</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Easton, Md.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Maurice E. Vennema, Sr. Easton, Md.</b>					<b>25a. REC'D BY REGISTRAR</b> <b>SEP 14 1966</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>				





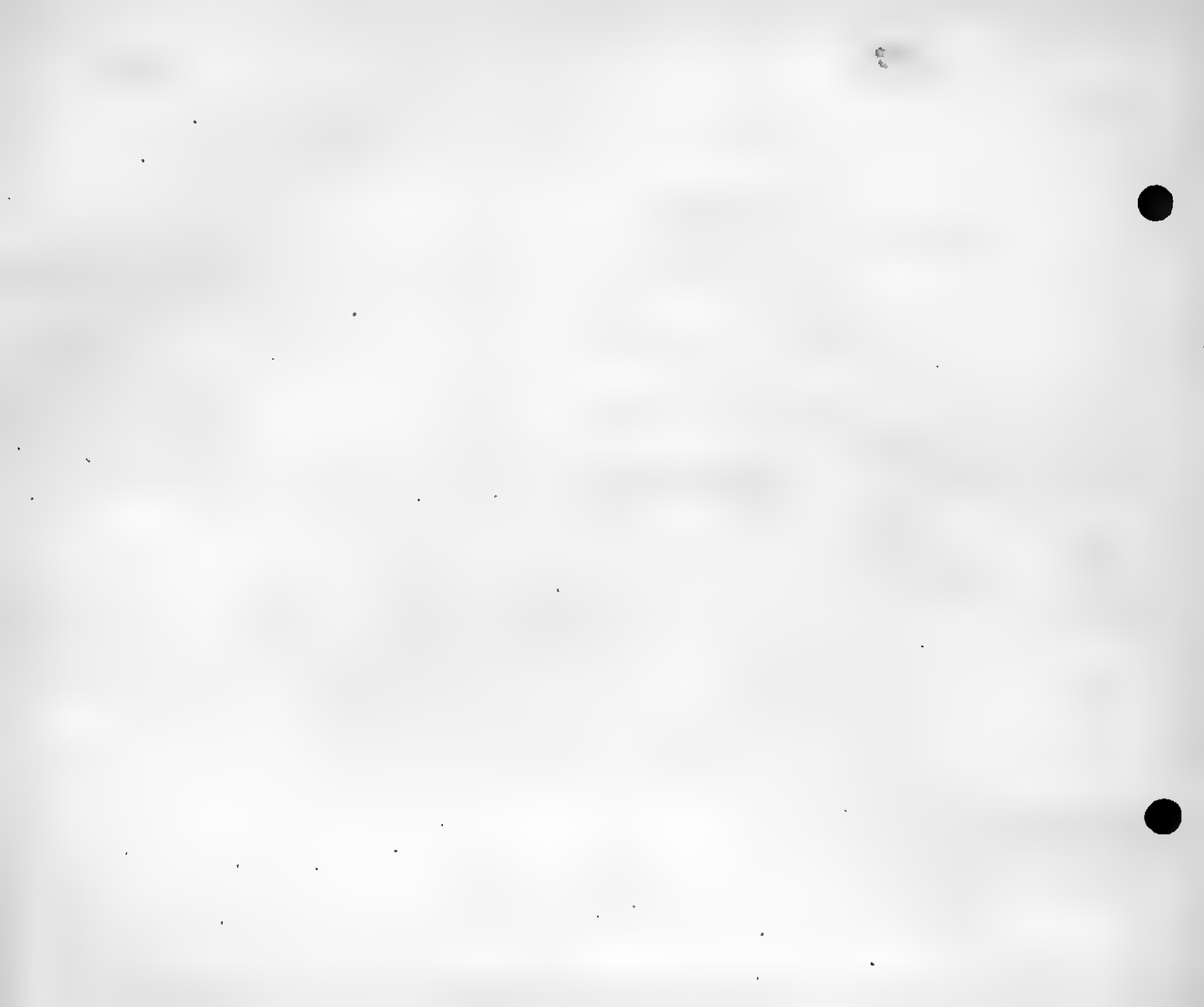
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13255

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Mathilda Elliott</u>		4. DATE OF DEATH Month Day Year <u>September 9 1966</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-1883</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Cummings</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dobson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records Easton, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Uremia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-7</u> , 19 <u>66</u> to <u>9-9</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>9-7</u> , 19 <u>66</u> and that death occurred at <u>9:45</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>R. Tyson</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-10-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD TYSON</u>				22d. ADDRESS <u>36 AURORA ST. EASTON Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richard NEW Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Talbot Md</u>			
24. FUNERAL DIRECTOR <u>James B. Doherty, Easton, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>James B. Doherty</u>			



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

Item #2b,c, & d Film Maryland STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
Item 8 Film 4361 4-2-66

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institutional residence, give admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Talbot		Easton		Md.		Talbot J.A.	
c. LENGTH OF STAY IN lb		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
17 yrs.		(Home for Aged Women, Inc.) 108 N. Higgins		Easton, Md. 21939 / Hyeentown		108 N. Higgins	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Lavania May Ely				9/19/66		19	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	W		4/26/66 1877	89 yrs.	Months Days	Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
house wife						Queen Anne, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William D. Wrightson				Martha A. Thursby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
no				none		records of Home for Aged Women of Easton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i>				2 days			
4200 DUE TO							
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i>				many yrs.			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<i>Diabetes</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour a.m. p.m.		19		White <input type="checkbox"/> Not White <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to..... 19 Sep....., 1966, that (I) (we) last saw the deceased alive on..... 18 Sep....., 1966, and that death occurred at..... A.M., from the causes and on the date stated above.							
22a. SIGNATURE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
Stephen B. Carney M.D.				22d. ADDRESS		19 Sep 66	
22c. PHYSICIAN'S NAME (Type)							
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		9/21/66		Loudon Park		Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
The Jay D. Heverin Funeral Home, Easton, Md.				SEP 26 1966		J. J. Jones Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in a vault within 72 hours after death.

VR A15ME (5)  
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13253

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, + institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTON, Rt. 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HENRY</u> Last <u>EMORY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-12-1882</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John EMORY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET CLAYTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>219-14-4450</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASCVD</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. Welty</u> M.D.		22. DATE SIGNED <u>9-8-66</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-10-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW CHAPEL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>Talbot Md</u>
24. FUNERAL DIRECTOR <u>James B. Daskill</u> ADDRESS <u>EASTON, Md.</u>		25a. REC'D BY REG. STRAR DATE <u>SEP 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





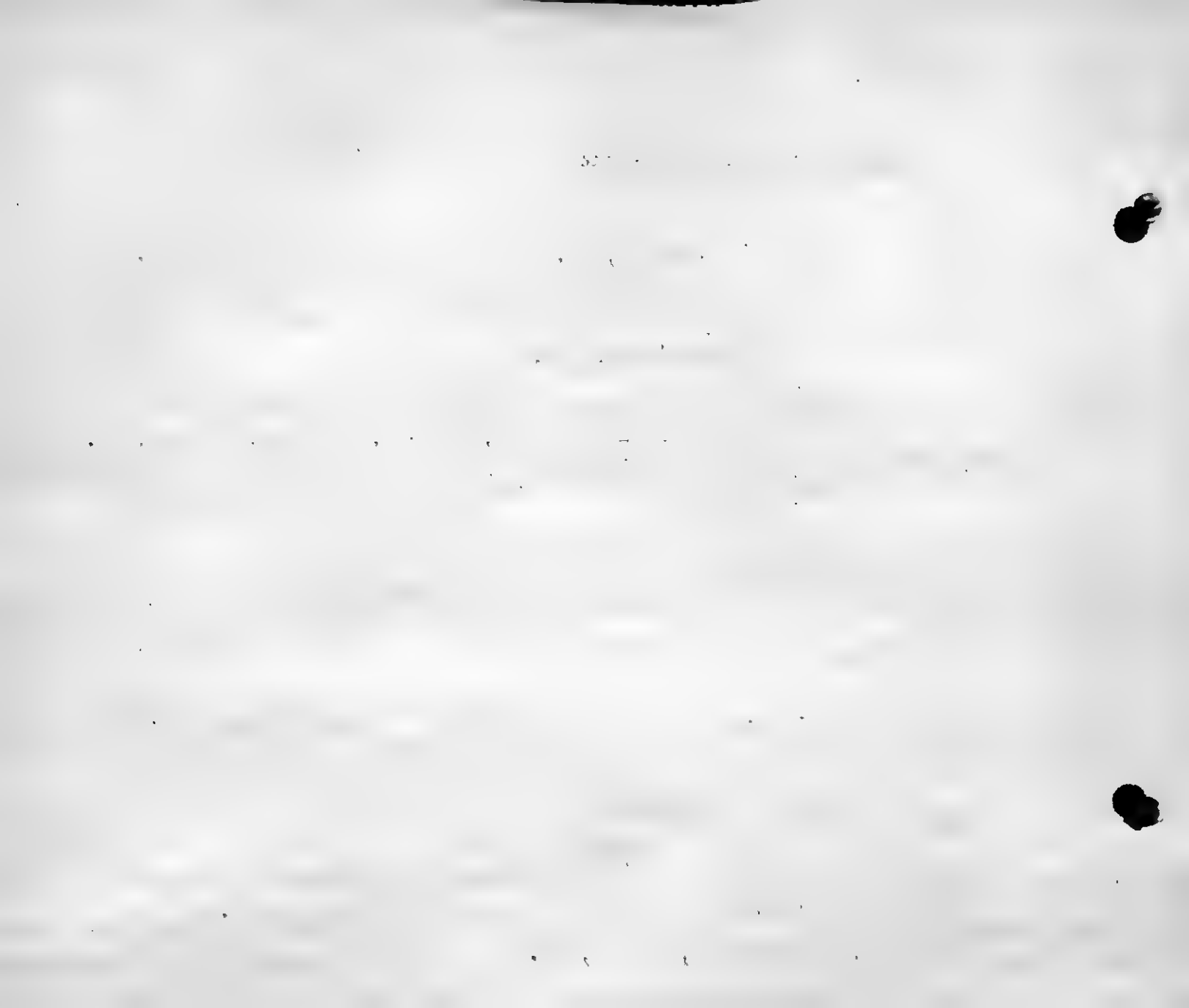
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the body. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Condova</u> (rural) <del>XX</del>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Condova</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) <u>James Otis Faulkner, Sr.</u>					4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1966</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/12/1932</u>		9. AGE (in years last birthday) <u>34</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Norris E. Taylor Contractors, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Otis Faulkner</u>					14. MOTHER'S MAIDEN NAME <u>Anna Brooks</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>213-26-7434</u>		17. INFORMANT <u>Mrs. James O. Faulkner, Condova, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>15. W. head</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year <u>8</u> <u>3</u> <u>9-9</u> <u>1966</u> Hour <u>p.m.</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>					20f. (City or town) (County) (State) <u>in Easton Tal Md</u>						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Louis M. Melty</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>INELTY</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					DATE SIGNED <u>9-9-66</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>9/13/1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>		
23. FUNERAL DIRECTOR <u>MURICE E. NEUNAM &amp; SON, Easton, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>SEP 15 1966</u>					24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2b & c Film #110/3/66 ps											
CERTIFICATE OF DEATH										13259	
1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN lb <u>24 days</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Easton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS <u>222 Glenwood Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Robert Alfred Gooby</u>						4 DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1966</u>					
5 SEX <u>Male</u>		6 COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2-23-1881</u>		9 AGE (In years) <u>85</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH Gooby</u>						14. MOTHER'S MAIDEN NAME <u>MARY Roberts</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>				16. SOCIAL SECURITY NO. <u>179-01-1228</u>		17. INFORMANT <u>HOSPITAL REC. EASTON, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> DUE TO (b) <u>Cerebral hemorrhage</u> DUE TO (c) <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia (months) Diabetes mellitus (years)</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 29, 1966</u> to <u>Sept 22, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept 22, 1966</u> , and that death occurred at <u>3:45 PM</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Dale R. Kollman</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 22, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dale R. Kollman, M.D.</u>						22d. ADDRESS <u>12 N. Hanson; Easton, Md.</u>					
23a. BURIAL, CREMATION, or other disposal <u>BURIAL</u>		23b. DATE THEREOF <u>8-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Richards. Cem</u>				23d. LOCATION (City or Town) (County) (State) <u>Easton, Talbot, Md.</u>			
24. FUNERAL DIRECTOR <u>James E. Galt, Jr., M.D.</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right;">13260</div>											
1. PLACE OF DEATH a. COUNTY <i>TALBOT</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>TALBOT</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>48 hr.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RURAL TRAPPE</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>						d. STREET ADDRESS <i>LITTLE MT. HOPE FARM</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Wesley Thomas</i>		First <i>Wesley</i> Middle <i>Thomas</i> Last <i>Hallowell</i>		4. DATE OF DEATH Month <i>9</i> Day <i>8</i> Year <i>1966</i>							
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 31, 1908</i>		9. AGE (In years last birthday) <i>58</i> yrs.		10. FUNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>8</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RESIDENT: AUTO SALES</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>AUTOMOTIVE SALES</i>		11. BIRTHPLACE (County & State, or foreign country) <i>DORCHESTER Co., MD.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JOHN WESLEY HALLOWELL</i>						14. MOTHER'S MAIDEN NAME <i>BELLE STEWART</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-30-8063</i>		17. INFORMANT <i>MRS. GLENN T. HALLOWELL</i>		Address <i>LITTLE MT. HOPE FARM TRAPPE MD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive upper intestinal hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Esophageal varices</i> DUE TO (c) <i>Cirrhosis of the liver</i>										INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>(?)</i> <i>(?)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10 June</i> , 19 <i>66</i> , to <i>8 Sept</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>7 Sept</i> , 19 <i>66</i> , and that death occurred at <i>8:00</i> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Thurston Harrison</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8 Sept 66</i>			
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>						22d. ADDRESS <i>Easton Maryland</i>					
23a. BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)		23b. DATE THEREOF <i>9-10-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i>				23d. LOCATION (City, town or county) (State) <i>EASTON - MD.</i>			
24. FUNERAL DIRECTOR <i>Charles Judge</i>				ADDRESS <i>Easton Md</i>		25a. REC'D BY REGISTRAR <i>SEP 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



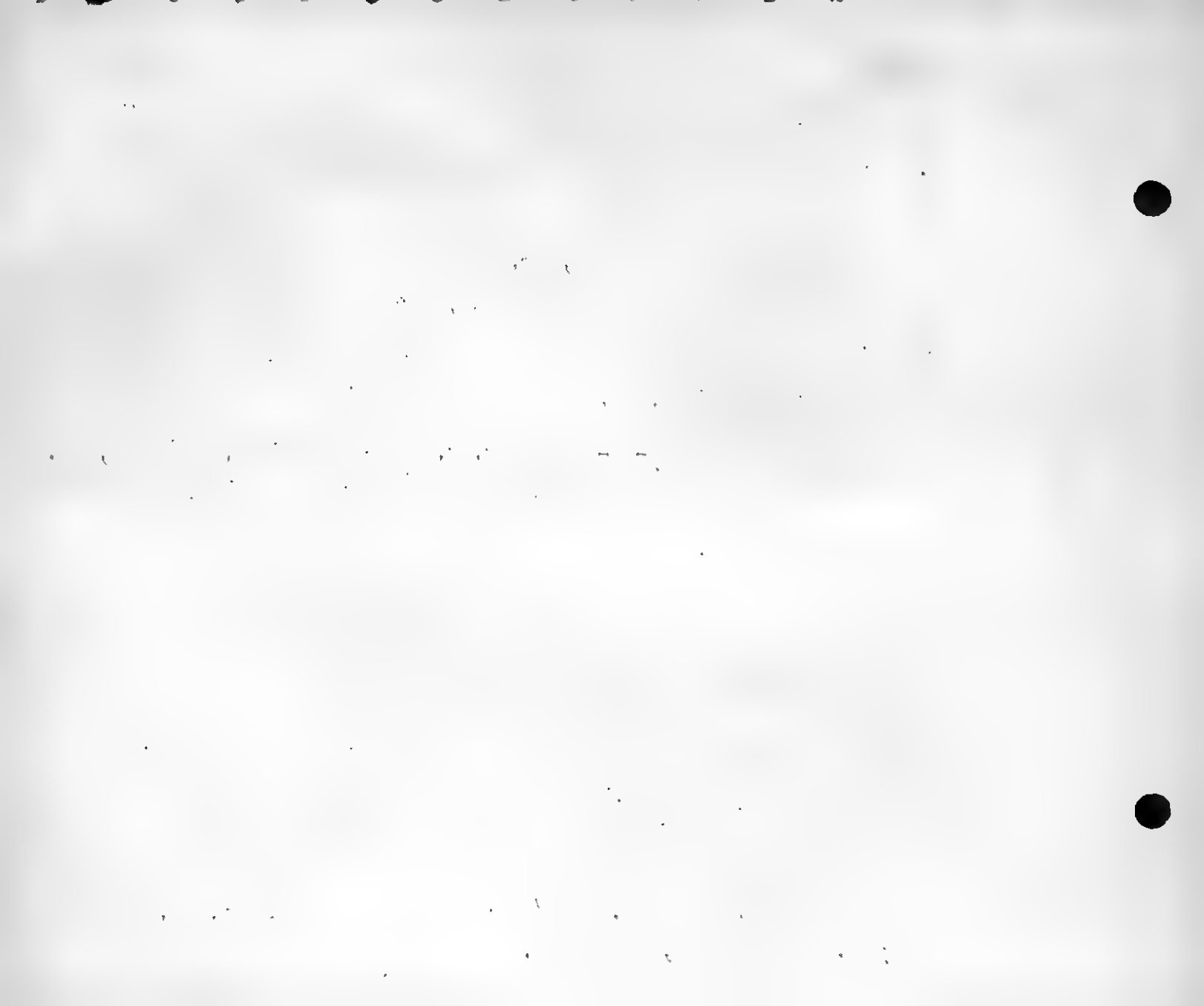


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
Item #1d Film #G361 9/26/66 bc									
13261									
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>					c. LENGTH OF STAY IN ID MARYLAND				
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Tilghman</i>					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Dr. Office's Spencer Building</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Dobson</i> Last <i>Harrison, Jr.</i>					4. DATE OF DEATH Month <i>9</i> Day <i>15</i> Year <i>1966</i>				
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/14/1920</i>		9. AGE (In years last birthday) <i>46</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Garage</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Talbot Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>James Dobson Harrison, Sr.</i>					14. MOTHER'S MAIDEN NAME <i>Mary Mushaw</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>WWII</i>					16. SOCIAL SECURITY NO. <i>220-01-8388</i>				
17. INFORMANT <i>Mrs. J. Dobson Harrison, Tilghman, Md.</i>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Child Hypertension, Myocardial Infarction</i> DUE TO <i>Coronary Artery Hardening</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> (c) <i></i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>					INTERVAL BETWEEN ONSET AND DEATH <i>147</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (i) (this hospital) attended the deceased from <i>9-15</i> , 19 <i>66</i> , to <i>9-15</i> , 19 <i>66</i> ; that (i) (we) last saw the deceased alive on <i>9-15</i> , 19 <i>66</i> ; and that death occurred at <i>6:15</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>J. Frank White</i>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <i></i>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>					23b. DATE THEREOF <i>9/18/1966</i>				
23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>					23d. LOCATION (City, town or county) (State) <i>Tilghman, Md.</i>				
24. FUNERAL DIRECTOR <i>WILLIAM E. NEWMAN &amp; SON, Easton, Md.</i>					25a. REC'D BY REGISTRAR OATE <i>SEP 20 1966</i>				
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13262

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EMSION</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>CARLTON</u> Middle <u>S</u> Last <u>HERSHEY</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>65</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Hershey</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>217-54-5254</u>	
17. INFORMANT <u>Mrs. Charles Fontenbaugh, Oxford, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) <u>2nd &amp; Benach Nephrotic Prostate</u> DUE TO (c) <u>Supra Eptostomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John N. Robinson</u>		22b. DATE SIGNED <u>9/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John N. Robinson</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/29/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landing Neck</u>	23d. LOCATION (City or Town) (County) (State) <u>Trappe, Md.</u>
24. FUNERAL DIRECTOR <u>Marcelle E. Newnam &amp; Son</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY (In 1b) <u>7 d.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTERVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hospital Records</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>ITALY</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 1, 1923</u>	9. AGE (In years last birthday) <u>43</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (County & State, or foreign country) <u>QUEEN ANNE, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Italy</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE ITALY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-07-9694</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic nephritis (nephrosclerosis and diabetic nephropathy)</u> DUE TO (c) <u>Hypertension and diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure. Secondary anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>66</u> to <u>9/8</u> , 19 <u>66</u> (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>	
22d. ADDRESS <u>Easton, Md.</u>				22e. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Carmichael Cem -</u>		23d. LOCATION (City or Town) (County) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>James E. Jones, Easton, Md.</u>				25. ADDRESS			





## CERTIFICATE OF DEATH

13264

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>PRICE</b>	
3 NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>JARRELL</b>		4 DATE OF DEATH Month <b>Sept</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12-1910</b> 55 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>xx</b>	9. AGE (In years last birthday) <b>55</b> yrs
11 BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HARRY JARRELL</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE TODD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MRS. MYRTLE JARRELL</b>		Address <b>CHURCH HILL MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Uncertain</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 17</b> , 19 <b>66</b> to <b>Sept 26</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Sept 26</b> , 19 <b>66</b> , and that death occurred at <b>7:30</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Trever</b>		22b. DATE SIGNED <b>9-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT W. TREVER</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>SEPT. 28</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHURCH HILL</b>	23d. LOCATION (City or town) (County) (State) <b>CHURCH HILL MD.</b>
24. FUNERAL DIRECTOR <b>Edgar L. Lane</b>		25. REC'D BY REGISTRAR <b>SEP 27 1966</b>	
ADDRESS <b>Church Hill, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13265

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>Box 204</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Anna Wilhelmine Leasing</u>		4. DATE OF DEATH Month Day Year <u>91 24 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1899</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Schlothauer</u>		14. MOTHER'S MAIDEN NAME <u>Minnie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>Mrs. Helen Loukides</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma metastatic to lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and liver, primary unknown</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-2</u> , 19 <u>66</u> , to <u>9-24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>66</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>9-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto Md</u>		25a. REC'D BY REGISTRAR <u>J. E. Boulares Greensboro, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 27 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If necessary, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13266

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>Box 8 21665</u>	
3 NAME OF DECEASED (Type or print) <u>Dorothy Virginia Kennard</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 6, 1899</u>
9 AGE (In years last birthday) yrs. <u>67</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME <u>Edward Doudiken, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Shipley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service) <u>No None</u>	
16. SOCIAL SECURITY NO.		17 INFORMANT <u>Mr. Stewart R. Kennard</u> Address <u>same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uterine Cancer</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Carcinoma of Ovary</u> (b) <u>Uterine Cancer</u> (c) <u>Uterine Cancer</u>		INTERVA. BETWEEN ONSET AND DEATH <u>2 yr.</u> <u>3 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Vascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Sept 1966</u> to <u>Sept 1966</u> , that (I) (we) saw the deceased alive on <u>Sept 1966</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>W. J. Luchner &amp; Son</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
ADDRESS <u>North + Perm co.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>HILSBOT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>GAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRESTON RD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRESTON RD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 50</u>		d. STREET ADDRESS <u>R.F.D. # 1</u>	
3. NAME OF DECEASED (Type or print) <u>William Theodore</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>6th</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-02</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>roads board</u>	
11. BIRTHPLACE (State or foreign country) <u>Trenton, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes W W 1</u>		16. SOCIAL SECURITY NO. <u>218-12-1478</u>	
17. INFORMANT <u>Mrs. Sarah L. Kraus, Preston, Maryland</u>		Address <u>R.F.D. # 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
Conditions, if any, which gave rise to immediate cause (b) <u>4201</u>			
(c) <u>DUE TO</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>factory</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis S. Welty</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Louis S. Welty</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>9-6-66</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/9/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Preston, Maryland</u>	
23. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
ADDRESS <u>J. J. Frampton and Son, Federalsburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND, STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13268

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Worton</u> (Adult Lifetime)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>SEWELL</u> Middle <u>JEWELL</u> Last <u>LEE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 4 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. FUNDING 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Feed Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Florence Dowling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>161 03 4510</u>	
17. INFORMANT <u>Helen E. Lee Worton, Md. wife</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO <u>General Arteriosclerosis</u> (c) <u>General Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Sigmoid Colon - 6 days post-op</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3:45 PM</u> , 19 <u>66</u> , to <u>9:27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-27</u> , 19 <u>66</u> , and that death occurred at <u>5 p.m.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>R. Lane Wroth</u>	
22b. DATE SIGNED <u>9-28-66</u>		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>		22e. ADDRESS <u>St. Michaels., Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Chestertown, Md.</u>	
24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		25a. REC'D BY REGISTRAR <u>SEP 30 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		25c. ADDRESS <u>Chester Town Md</u>	



FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 7/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13264 DOA 7<sup>30</sup> AM

1 PLACE OF DEATH a COUNTY <b>TALBOT</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>QUEEN ANNES</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL QUEENSTOWN</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>GERALD ROBERT LYON</b>		4 DATE OF DEATH Month <b>9</b> - Day <b>22</b> - Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 12, 1909</b>
9 AGE (in years, last birthday) <b>57</b> yrs		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
11 BIRTHPLACE (State or foreign country) <b>Waldwick, Bergen Co., N.J.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Byron Lyon</b>		14 MOTHER'S MAIDEN NAME <b>FLORENCE MERCER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16 SOCIAL SECURITY NO <b>100-09-2238</b>	
17 INFORMANT <b>WIFE</b> Address <b>Mrs. Mary Frances Lyon, Queenstown, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edw. K. Reed</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Edw. K. Reed</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>Sept. 24, 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>		23d LOCATION (City or town) (County) (State) <b>Centerville, Maryland 21617</b>	
24 FUNERAL DIRECTOR <b>Don H. Butler, Jr., Butler Bros., Centerville, Md.</b>		25a REG'D BY REGISTRAR <b>SEP 21 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	

22. DATE SIGNED  
9-22-66



# FOR STATE HEALTH DEPT

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VR A15ME (A)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13271

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <del>CARROLL</del> <b>Talbot</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>MAIN ST. P.O. Box 161</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Conroy</b> Last <b>Marth</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23, 1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>	9. AGE (n years last birthday) yrs <b>59</b>
11. BIRTHPLACE (State or foreign country) <b>Talbot Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Peter Marth</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Conroy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>21-5-18-4116</b>	
17. INFORMANT <b>Mrs. Mabel Marth</b>		Address <b>Trappe Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion of prior Coronary insufficiency</b> 4211 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>insufficiency</b> (c) <b>insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>3 40 p.m. 8-15- 1966</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Lewis D. Welty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Welty</b>		MD. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		for DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Sept 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Park</b>	23d. LOCAT ON (City or town) (County) (State) <b>P.O. Box 161 Talbot Md</b>
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REG STRAR DATE <b>SEP 19 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13272

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>		c. LENGTH OF STAY IN IL <b>3 wks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boston</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rio Vista Nursing Home</b>		d. STREET ADDRESS <b>410 North St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPHINE HOWETH MILES</b>		4. DATE OF DEATH Month Day Year <b>September 24, 1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1885</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>Charles W. Howeth</b>		14. MOTHER'S MAIDEN NAME <b>Laura Dodson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>MRS MARY FORD UPPER FAIRMOUNT, MD.</b>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>cachexia - severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last <b>atherosclerotic cardiovascular</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Very advanced senile changes.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>---</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>9-10-1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>St. Michaels, Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9-10-1966</b> to <b>9-26-1966</b> , that (I) (we) last saw the deceased alive on <b>9-26-1966</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>GUY M. REBSER, Jr., M. D.</b>		22b. DATE SIGNED <b>9-26-66</b>		22c. PHYSICIAN'S NAME (Type) <b>GUY M. REBSER, Jr., M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/27/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ANDREW CEMETERY</b>	
23d. LOCATION (City, town or county) <b>PRINCESS ANNE, MD.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>LEVIN R. WILSON</b>		24b. ADDRESS <b>PRINCESS ANNE, MD.</b>		25a. REC'D BY REGISTRAR <b>OCT 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>					





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film # 100-822965-60

## CERTIFICATE OF DEATH

13273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
c. LENGTH OF STAY IN lb. <u>20 days</u>		d. STREET ADDRESS <u>11 Memorial Hospital</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise Mitchell</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9. AGE (In years last birthday) <u>82</u> yrs.
11. BIRTHPLACE (County & State or foreign country) <u>Talbot, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Demby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-2671</u>	
17. INFORMANT <u>Hosp. Rec.</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thromboses</u> DUE TO (b) <u>atherosclerosis cerebrovascul</u> DUE TO (c) <u>advanced senile changes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , 19 <u>52</u> to <u>9-22</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>9-22</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Guy M. Preeser</u> M.D.		22b. DATE SIGNED <u>9-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Guy M. Preeser</u>		22d. ADDRESS <u>St. Michaels Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-26-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Charles Thomas C.M.</u>	23d. LOCATION (City or town) (County) (State) <u>Talbot Md</u>
24. FUNERAL DIRECTOR <u>James B. Dashiell</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James B. Dashiell</u>	



CERTIFICATE OF DEATH

13274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON 21 hrs 30 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>--</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Josephine</b> Last <b>Moore</b>		4. DATE OF DEATH Month <b>9-</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>89</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>Charleston, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Stillson</b>		14. MOTHER'S MAIDEN NAME <b>Carroll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Lawrence R. Moore</b>		Address <b>Vienna, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic (vascular) disease</b> DUE TO (c) <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 11, 1966</b> to <b>Sept 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 11, 1966</b> , and that death occurred at <b>2:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>R. Lane Wroth</b>		22b. DATE SIGNED <b>9-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Lane Wroth</b>		22d. ADDRESS <b>M.D. St. Michaels, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>September 14, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miami City Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Miami Florida</b>
24. FUNERAL DIRECTOR <b>Tramptm Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Federalburg, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>SEP 26 1966</b>		25c. REGISTRAR'S SIGNATURE <b>John J. J...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

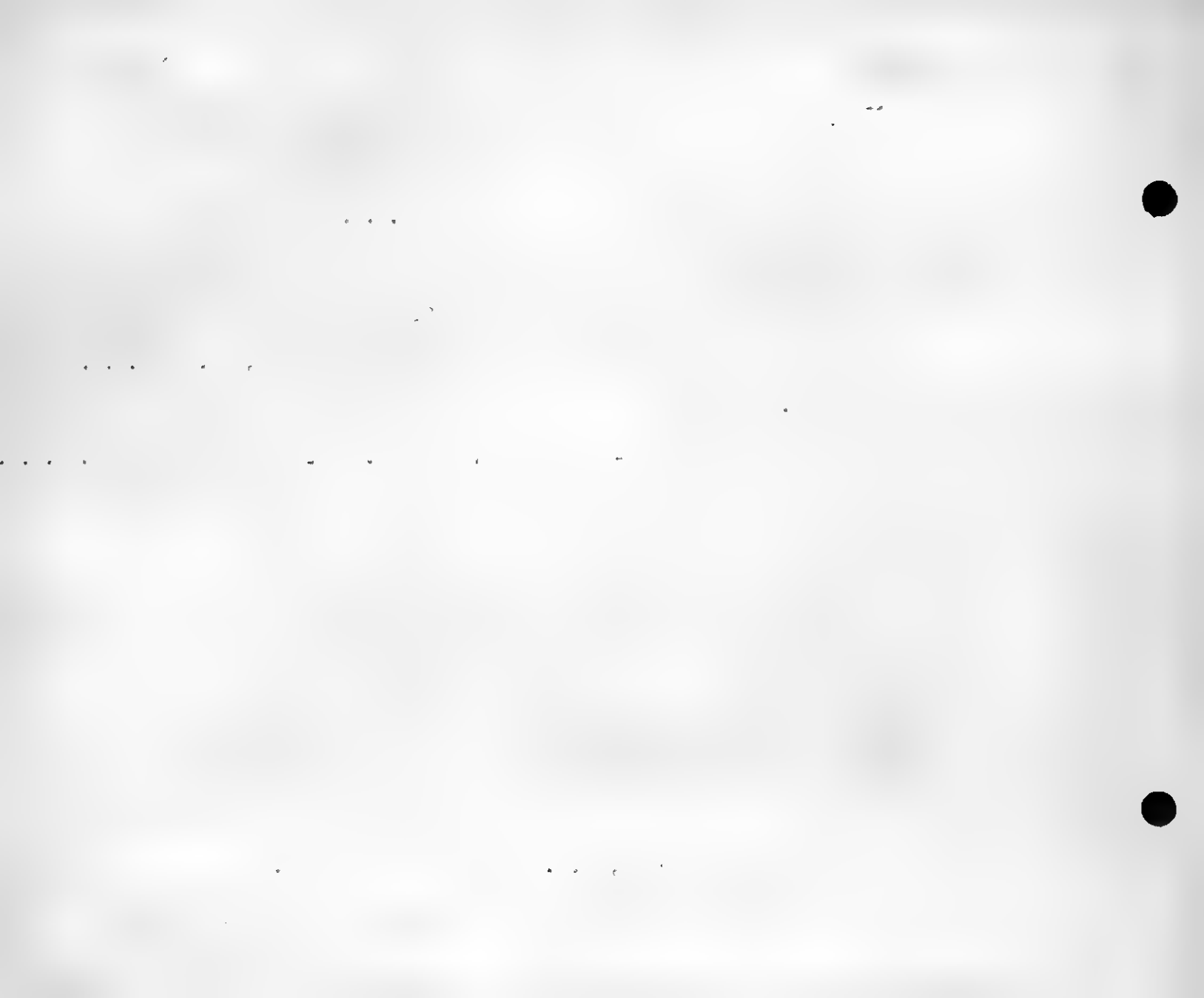
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13275

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>7 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>R.F.D.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Lloyd James</u> First <u>Murphy</u> Middle Last		<b>4. DATE OF DEATH</b> <u>September 14</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel J. Murphy</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>201-05-4572</u>		17. INFORMANT <u>Mrs. Hazel H. Murphy, Rhodesdale, Md. R.F.D.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 ____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>14 Sep</u> , 19 <u>66</u> , to <u>14 Sep</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>14 Sep</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		22b. DATE SIGNED <u>16 Sep 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney, M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>September 18, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brookview, Maryland</u>	
24. FUNERAL DIRECTOR <u>from Hampton Jr. Federalburg, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		25c. REGISTRAR'S NAME <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>One Year</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOUSE IN THE PINES EASTON</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>107 Church Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eulalia</b> Middle <b>Crocheron</b> Last <b>North</b>		4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1891</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR: Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eugene Crocheron</b>		14. MOTHER'S MAIDEN NAME <b>Trifinia Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mr. Hamilton North, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4/100 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>many years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/24/65</b> , 19 <b>65</b> to <b>9/10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9/7</b> , 19 <b>66</b> , and that death occurred at <b>4:15 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen O. Canby</b>		22b. DATE SIGNED <b>9-12-66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 12 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>28 Compton F.H. Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>NEILLIE</u> Middle <u>CHATMAN</u> Last <u>PAYNE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-24-1286A</u>	
17. INFORMANT <u>Hospital Records</u> Address <u>Easton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2nd degree burns rt. arm. Uremia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Spilled grease on arm cooking</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> e.m. <u>4</u> p.m. <u>1966</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Easton</u> (County) <u>Talbot</u> (State) <u>Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>66</u> to <u>9-11</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>9-11</u> , 19 <u>66</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED <u>9-13-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-14-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>
23d. LOCATION (City, town or county) <u>Talbot</u>		(State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>James B. Washell</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Easton, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
		DATE <u>SEP 21 1966</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
5M 1/63

166m-#1d-11m-#330 9/20/66 pg

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13278

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>River Road (R.D. #1)</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>		3. NAME OF DECEASED (Type or print) First <i>Luther</i> Middle <i>Goldsborough</i> Last <i>Phippin</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>12</i> Year <i>1966</i>		5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 6, 1918</i>		9. AGE (in years last birthday) <i>48</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		11. BIRTHPLACE (State or foreign country) <i>Hebron, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charlie Wesley Phippin</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Parsons</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Norma Phippin, RD 1 Salisbury, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
21. ACTUAL SIGNATURE <i>Louis O. Melty</i>		21. EXAMINER'S NAME (Type) <i>WELTY</i>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		21. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		21. DATE SIGNED <i>9-12-66</i>		21. Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/15/1966</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hebron Cemetery</i>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR <i>MURRICE E. NEWMAN &amp; SON, Easton, Md.</i>		23. ADDRESS		24a. REC'D BY REGISTRAR <i>SEP 15 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		24c. DATE		24d. TIME		24e. SIGNATURE		24f. TIME							

MEDICAL CERTIFICATION



# FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #2c & d info. taken from birth cert.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13279

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived f. institution. Residence before adm. ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb. <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>62 Graham St.</u>	
3. NAME OF DECEASED (Type or print) <u>Penny Linda Sherwood</u>		4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/66</u>
9. AGE (in years last birthday) <u>6 weeks</u>		10. IF UNDER 24 HRS Months <u>1</u> Days <u>14</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Sherwood</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother Mrs. Josephine Sherwood</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized septicemia - acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>? middle ear infection?</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis A. Kelly</u> M.D.		22. DATE SIGNED <u>9-26-66</u>	
EXAMINER'S NAME (Type) <u>KELTY</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF <u>9-26-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Talbot C.M.</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton Talbot Md</u>
24. FUNERAL DIRECTOR <u>James B. Nash</u>		25a. REC'D BY REGISTRAR <u>James B. Nash</u>	
ADDRESS <u>Easton Md</u>		25b. REGISTRAR'S SIGNATURE <u>James B. Nash</u>	
DATE <u>OCT 3 1966</u>			

6-200095

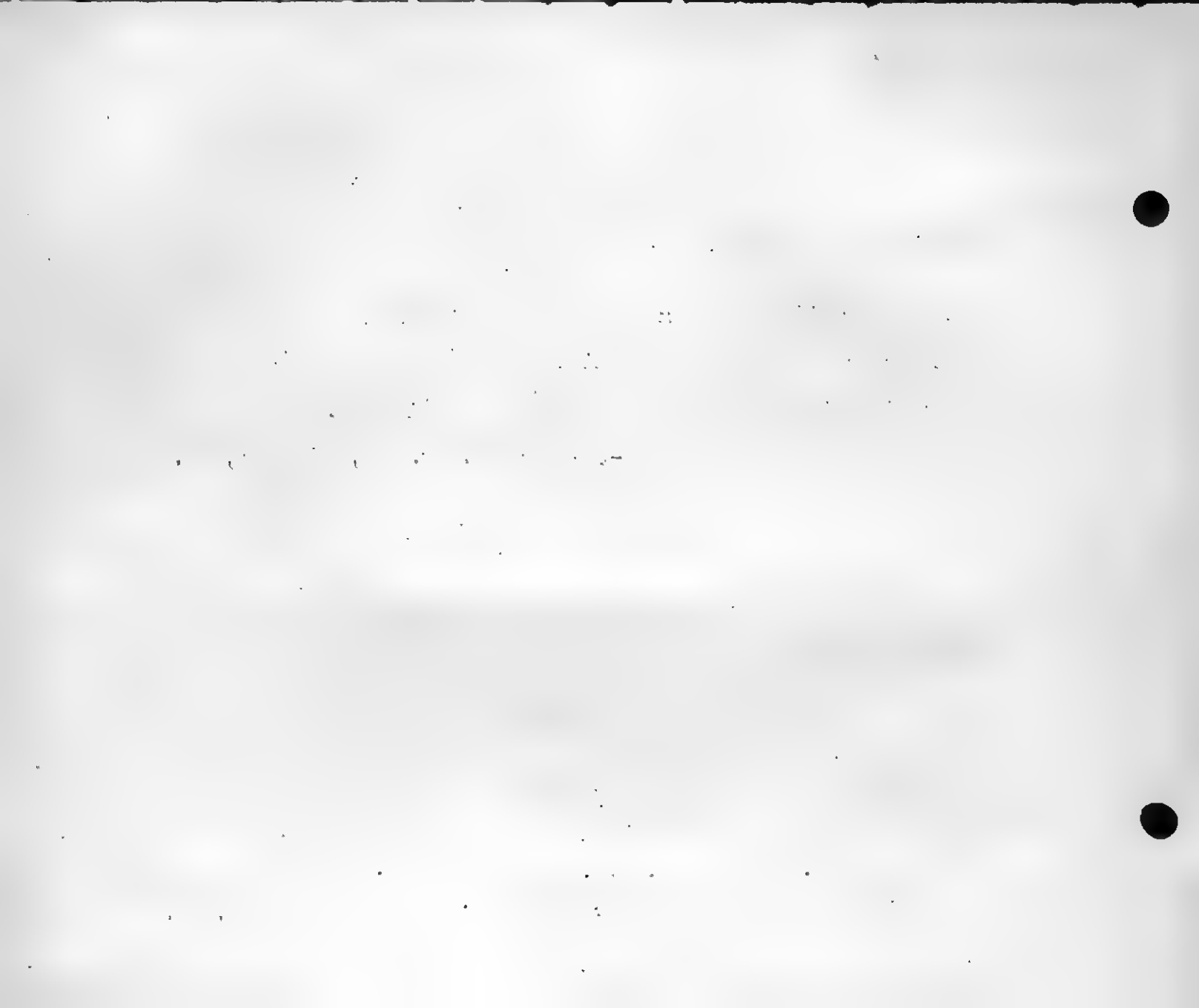


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M  
36  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13280  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Howard Thomas Sinclair</u>		4. DATE OF DEATH <u>9/14/1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1881</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marine Police</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gus Sinclair</u>		14. MOTHER'S MAIDEN NAME <u>Tabitha Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-1678230</u>	
17. INFORMANT <u>Mrs. Wm. Roe, Tilghman, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Embolus</u> DUE TO (b) <u>Chronic Atherosclerosis of Coronary Arteries</u> DUE TO (c) <u>Chronic Hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Hypertrophy</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 14, 1966</u> to <u>Sept 14, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 14, 1966</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. Lane Wroth</u>		22b. DATE SIGNED <u>9-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth, M.D.</u>		22d. ADDRESS <u>St. Michaels</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/16/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sherwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sherwood, Md.</u>	
24. FUNERAL DIRECTOR <u>M. E. Newman &amp; Son</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1966</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item #20 & d Film #G-31 97426 pc

13281

1. PLACE OF DEATH a. COUNTY <b>Talbot</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL EASTON</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL Bellevue EASTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>Box 531</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>E</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEA FOOD</b>	9. AGE (in years last birthday) <b>53</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Talbot, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CLARENCE GIBSON</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE PHILLIPS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>160-34-0693</b>	
17. INFORMANT <b>William Smith</b>		Address <b>Belle Vue, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic Bacteremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myelogenous</b> (c) <b>Leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-2</b> , 19 <b>66</b> to <b>9-7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-7</b> , 19 <b>66</b> , and that death occurred at <b>3:51</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>James B. Nash</b>		22b. DATE SIGNED <b>9-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James B. Nash</b>		22d. ADDRESS <b>Easton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9-10-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Richards Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Easton Talbot Md.</b>
24. FUNERAL DIRECTOR <b>James B. Nash</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## CERTIFICATE OF DEATH

13282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>		d. STREET ADDRESS <u>Ridgely Ct. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Pritchett</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>17</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE (in years last birthday) yrs <u>78</u>
11. BIRTHPLACE (County & State or foreign country) <u>CAROLINE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PHILIP PRITCHETT</u>		14. MOTHER'S MAIDEN NAME <u>MIRAR PRITCHETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>310-07-7372</u>	
17. INFORMANT <u>MIRAR PRITCHETT</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>metastatic to liver</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>2 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trevor</u>		22b. DATE SIGNED <u>9/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trevor</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-24-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SAND TOWN CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>Caroline Md.</u>
24. FUNERAL DIRECTOR <u>James H. Dashiell, Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right;">13283</div>																												
<b>1. PLACE OF DEATH</b> a. COUNTY <i>TALBOT</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b <i>18 min.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>CAROLINE</i> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>HARTMONY (PRESTON RFD)</i> d. STREET ADDRESS <i>—</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																						
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Maurice</i> Middle <i>Linwood</i> Last <i>Todd</i>			<b>4. DATE OF DEATH</b> Month <i>9-</i> Day <i>10-</i> Year <i>1966</i>			<b>5. SEX</b> <i>MALE</i>			<b>6. COLOR OR RACE</b> <i>WHITE</i>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <i>Nov. 14, 1906</i>			<b>9. AGE</b> (In years last birthday) <i>59</i> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																											
Months	Days																											
	Hours																											
	Min.																											
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Truck owner &amp; manager</i>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Pickle works</i>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Caroline County, Maryland</i>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>																
<b>13. FATHER'S NAME</b> <i>Frank Linwood Todd</i>						<b>14. MOTHER'S MAIDEN NAME</b> <i>Ella M. Gossage</i>																						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i>			<b>16. SOCIAL SECURITY NO.</b> <i>—</i>			<b>17. INFORMANT</b> <i>Mrs Maude M. Todd</i>			<b>Address</b> <i>Preston, Md. RFD</i>																			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> DUE TO (b) <i>acute myocardial infarction</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 hr</i> <i>1 1/2 hr.</i>																
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)																				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>10 Sept, 1966</i> <b>to</b> <i>10 Sept, 1966</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>10 Sept 1966</i> , <b>and that death occurred at</b> <i>3:30 P.</i> <b>from the causes and on the date stated above.</b>																												
<b>22a. SIGNATURE</b> <i>Arthur H. Harrisin</i>												<b>22b. DATE SIGNED</b> <i>10 Sept 66</i>																
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>THURSTON HARRISIN</i>						<b>22d. ADDRESS</b> <i>Carlton, Maryland</i>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>																				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>BURIAL</i>				<b>23b. DATE THEREOF</b> <i>9-12-66</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Hill Crest Cemetery</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>Federalburg, Md.</i>																				
<b>24. FUNERAL DIRECTOR</b> <i>from Hampton, Jr. Federalburg, Maryland</i>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <i>SEP 14 1966</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>																				



# CERTIFICATE OF DEATH

13284

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON MD</b>		c. LENGTH OF STAY IN 1b <b>10 d.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>	
d. STREET ADDRESS <b>3902 Southern Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FANNIE</b> Middle <b>E</b> Last <b>WAGNER</b>		4. DATE OF DEATH Month <b>9</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-1889</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles C. Brehm</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Herman H. Wagner RFD#1 Greensboro, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>4500</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured left hip</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 days</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerosis and anemias</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>	
20c. TIME OF INJURY - Month, Day, Year Hour - <b>2</b> p.m. <b>2 Sept 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Greensboro Caroline Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>19 66</b> , to <b>19 66</b> , that (I) (we) saw the deceased alive on <b>19 66</b> , and that death occurred at <b>4 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>H. Kinnamon, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>H. Kinnamon, M.D.</b>		22d. ADDRESS <b>Easton, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/19/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Catonsville, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Inc</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

13285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>5 hrs 2 mins</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL</u>		d. STREET ADDRESS <u>P.O. Box 79</u>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL</u> First Middle Last <u>WARNER</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CM</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Emory Staters</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Elizabeth Warner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	17. INFORMANT Address <u>Mabel Elizabeth Warner--Mother Cordova, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>6:20</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>J. Tyler Baker</u> M.D.		22b. DATE SIGNED <u>9/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Tyler Baker</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>INCINERATION</u>	23b. DATE THEREOF <u>9/30/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Memorial Hospital, Easton, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 5 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	







MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13282

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Easton Memorial</b>		e. STREET ADDRESS <b>Denton Road</b>	
3. NAME OF DECEASED (Type or print) <b>Artemas Wilhelm</b>		4. DATE OF DEATH <b>9 30 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1893</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist and Broiler Grower</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Wilmington, Delaware</b>	
10a. FATHER'S NAME <b>Harry E. Wilhelm</b>		10b. MOTHER'S MAIDEN NAME <b>Ada Daniels</b>	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		12. SOCIAL SECURITY NO. <b>221-03-6383</b>	
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 Sep, 1966</b> to <b>30 Sep, 1966</b> ; that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>66</b> and that death occurred at <b>9:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Stephen P. Carney</b>		22b. DATE SIGNED <b>10-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen P. Carney</b>		22d. ADDRESS <b>M.D. Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 3, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wilmington, Delaware</b>	
24. FUNERAL DIRECTOR <b>J. J. Frampton &amp; Son</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>OCT 4 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13294

13288

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>5 HR.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>20-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Woodrow W. Wilson</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1913</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Ethel James</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-07-4938</u>		17. INFORMANT Address <u>Mrs. John W. Wilson, Tilghman, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>150x</u> <u>cochepia - severe</u> DUE TO <u>adenoc. Esophagus</u> DUE TO <u>twisted intestines</u> (c) <u>twisted intestines</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>66</u> , to <u>9-18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-18</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Wm. B. Reese Jr.</u>				22b. DATE SIGNED <u>9-19-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Michael</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Cemetery</u>	
23d. LOCATION (City or Town) <u>Tilghman, Md.</u>				23e. REC'D BY REGISTRAR <u>SEP 21 1966</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Maurice E. Newman &amp; Son Easton Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> 20-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS <u>408 S. Washington Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Kemp</u> Last <u>Wyatt</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>19</u> - Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Percy Wyatt</u>		14. MOTHER'S MAIDEN NAME <u>Katie Kemp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-05-3709</u>	
17. INFORMANT <u>Mrs. Percy K. Wyatt, Easton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Acute myocardial infarction with</u> DUE TO (c) <u>acute pulmonary edema</u> <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9-19-66</u> <u>9-9-66</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>66</u> to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>5:40</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Trever</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever, M.D.</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL Specify <u>Burial</u>	23b. DATE THEREOF <u>9/21/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>Maunce E Newnam Son Easton Md</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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